

## CO-PAY 834

Co-Pay data will be mapped to the HIPAA 834 in the 2100A loop using fields AMT01 and AMT02.

There will be four occurrences of the AMT01/02 fields.

In the Trading Partner Agreements, Companion Documents, Final Mappings for AZ 834, Mappings and Reverse Mappings, and Transaction Worksheets will need to be documented that the Co-Pay data will be communicated to the Health Plans and Program Contractors on the Monthly Roster with Co-Pay data that will become effective on the first of the next calendar month.

The appropriate documentation must also include the fact that the first C1 occurrence will always represent the Co-Pay for Generic Rx, the second C1 will always represent Co-Pay for Brand Name Rx, the third C1 will always represent the Co-Pay for Non Emergency use of the ER and the fourth C1 will always represent the Co-Pay for Office Visits. If there is not a Co-Pay for one or more of the above described groups an entry in the loop for the C1 will be a 0 (zero dollars).

Additional information will have to be provided to the Health Plans to understand when a Co-Pay is mandatory vs. optional. The HIPAA 834 does not allow for use to specifically communicate that type of information. The Health Plans can be informed that if the first occurrence of the C1 (Generic RX) is 0 (no dollars) then that member's Co-Pay is optional. The Health Plans can then also assume that if the first occurrence of the C1 (Generic Rx) is than 0 then that member's Co-Pay is Mandatory.